

Chapter II

OVERVIEW OF THE MEDICAL BOARD OF CALIFORNIA

A. MBC Generally

Created in the Medical Practice Act,² the Medical Board of California is a semi-autonomous occupational licensing agency within the state Department of Consumer Affairs (DCA). MBC consists of 21 members who serve four-year terms. By law, twelve of MBC's members must be California-licensed physicians; the remaining nine members are so-called "public members" (non-physicians). Nineteen of MBC's members (including all of the physician members and seven of the public members) are appointed by the Governor; the remaining two public members are appointed by the Assembly Speaker and Senate Rules Committee, respectively.

MBC is semi-autonomous in that, pursuant to Business and Professions Code section 109(a), its members make final licensing and enforcement decisions (subject to judicial review). Uniquely, MBC is comprised of two autonomous divisions — the Division of Licensing (DOL) and the Division of Medical Quality (DMQ). MBC members are not merely appointed to the Board; they are specifically appointed to one of the two divisions. Comprised of seven members (four physicians and three public members), DOL focuses on the licensure of physicians and the regulation of several non-physician health care professions.³ DMQ, which consists of fourteen members (eight physicians and six public members), is the Board's enforcement arm; it oversees a large enforcement staff and adopts final decisions in disciplinary matters against its licensees. The Legislature rarely directs "the Medical Board" to do anything; instead, it aims its directives expressly at one of the divisions. Neither division reviews or ratifies the decisions of the other. No other DCA agency is structured this way.

² Bus. & Prof. Code § 2000 *et seq.*

³ In addition to physicians, DOL licenses registered dispensing optician firms (including contact lens dispensers and spectacle lens dispensers), research psychoanalysts, and licensed midwives; it also regulates unlicensed medical assistants.

The Medical Board is authorized to select an executive director, who serves at its pleasure.⁴ In turn, the executive director hires staff to head the Board’s licensing and enforcement divisions, and other important management, investigative, analytical, and support staff.

In 2004–05, MBC regulated over 120,000 physicians, of which almost 93,000 reside and practice in California. The Medical Board receives no funding or support from the state’s general fund. MBC is funded entirely by physician licensing, renewal, and application fees; as such, it is characterized as a “special-fund agency.” In 2004–05, MBC’s annual budget was \$41 million — up from its \$38 million budgets during 2003–04, 2002–03, and 2001–02, when a state hiring freeze forced both budget and staffing constrictions on the Board.

B. MBC’s Enforcement Program

As noted above, MBC is responsible not only for licensing physicians, but also for reviewing the quality of medical practice carried out by California physicians; conducting disciplinary proceedings in cases of unprofessional conduct; and generally enforcing the disciplinary and criminal provisions of the Medical Practice Act, other relevant statutes and regulations, and applicable professional standards.⁵ MBC accomplishes this latter function through its Division of Medical Quality.

MBC’s enforcement program is large, complex, and fragmented across three state agencies. DMQ oversees a large enforcement staff that receives, screens, and investigates complaints and reports of physician misconduct and negligence. These staff are based at headquarters in Sacramento and at eleven district offices throughout California. Complaints and reports of physician misconduct are received at the Sacramento-based Central Complaint Unit, where they are screened and — if meritorious — shipped out to one of the regional district offices for formal investigation. Once a Medical Board investigator (assisted by physician employees called “medical consultants” and often by external expert physician reviewers) has determined that sufficient evidence exists to take disciplinary action, the matter is transmitted to a separate agency — the Health Quality Enforcement Section of the Attorney General’s Office; HQE has six offices throughout the state. A deputy attorney general from HQE then files an “accusation,” a written statement of formal charges, which triggers a panoply of due process rights for the subject physician. Absent settlement, the charges then become the subject of an evidentiary hearing presided over by an administrative law judge (ALJ) from another separate agency — the Medical Quality Hearing Panel of the Office of Administrative Hearings — at which each side presents its case. After the case is “submitted,” the ALJ drafts a proposed decision, including findings of fact, conclusions of law, and recommended

⁴ Bus. & Prof. Code § 2020.

⁵ *Id.* § 2004.

discipline. That proposed decision is referred back to MBC's Division of Medical Quality, where it is reviewed by one of two "panels" of DMQ, each consisting of seven members (four physicians and three public members). The assigned DMQ panel makes MBC's final disciplinary decision, which is then subject to potentially three levels of review by the courts. Contested MBC disciplinary matters often consume five to eight years, during which time most respondent physicians are free to continue practicing medicine.

Business and Professions Code section 2234 sets forth grounds for MBC disciplinary action, including gross negligence (an extreme departure from applicable professional standards); repeated negligent acts; incompetence; the commission of any act of dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician; and the violation of any provision of the Medical Practice Act. In MBC disciplinary matters, the burden of proof is on the Board, and MBC must prove its case by "clear and convincing evidence to a reasonable certainty."⁶

Business and Professions Code section 2227 sets forth an array of sanctions that DMQ may impose on a licensee for a disciplinable violation, including license revocation, suspension, probation on specified terms and conditions, and the issuance of a public reprimand. Through probation, DMQ may restrict a license (for example, it may prohibit a physician from prescribing certain types of controlled substances, practicing without a third-party chaperone, or engaging in solo practice) or condition continued practice on participation in the Board's Diversion Program for substance-abusing licensees; require a physician to take and pass a professional competency exam, psychiatric examination, ethics and/or other continuing education courses, or to undergo psychotherapy or other medical evaluation and treatment; and/or require participation in the Physician Assessment and Clinical Education (PACE) program. Additionally, section 2233 permits DMQ to issue a "public letter of reprimand"; section 125.9 allows Division staff to impose citations and fines on physicians for minor violations of the Medical Practice Act; and other Code sections permit DMQ to assess civil penalties against physicians for specified misconduct.

Theoretically, both the ALJ's recommendation and DMQ's imposition of specific disciplinary sanctions are based on "disciplinary guidelines" formulated by DMQ. These guidelines, which are regularly reviewed and updated by MBC enforcement staff and the Division, are incorporated by reference in DMQ regulation⁷ and represent DMQ's preferred range of sanctions for every given violation of the Medical Practice Act and applicable professional standards. They are intended to promote statewide consistency in disciplinary decisionmaking to ensure that similarly situated physician respondents are treated similarly — an important component of due process and equal protection.

⁶ See, e.g., *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal. App. 3d 853.

⁷ 16 CAL. CODE REGS. § 1361.

MBC's enforcement program is enormously important to California consumers, who depend on it to rid the marketplace of physicians who are negligent, incompetent, dishonest, or impaired. MBC is the only entity in the state authorized to revoke, suspend, or restrict the license of a California physician in order to protect "the public at large, *i.e.*, all consumers of medical services in California."⁸ Most California consumers visit a physician regularly, and most physicians see and treat dozens of patients per day. Negligence or misconduct by a physician can easily cause the "irreparable harm" that justifies the existence of most state licensing programs. Even one moment of negligence or impairment by a physician can result in serious injury to or the death of a patient. Thus, the importance of the effective, efficient, and decisive functioning of MBC's enforcement program cannot be overstated.

MBC's enforcement program is also important to physicians who practice medicine in California. Those who become licensed as physicians have spent many years in and many dollars on medical school, clinical education and postgraduate training programs, and often additional training and examinations necessary to become certified by national specialty boards; the law views their license as a property right which may not be taken by the state absent substantive and procedural due process. All segments of society need competent and qualified physicians to assist in preventing, detecting, and treating disease and other medical conditions. Thus, trained physicians should not be barred from the marketplace for insignificant reason. In this era of managed care, the impact of MBC investigative and disciplinary activity can have momentous ramifications for a physician's ability to practice medicine. Thus, the fairness, consistency, and quality of MBC disciplinary decisionmaking are of significant import to California's physician population.

These sometimes competing priorities of consumer protection and physician marketplace access have been reflected in the Legislature's evolving definition of the paramount goal of MBC's enforcement program. Prior to 1990, Business and Professions Code section 2229 directed MBC, in exercising its disciplinary authority, to "take such action as is calculated to aid in the rehabilitation of the licensee" — for example, by ordering additional education or restricting (rather than revoking) the license. In 1990, however, the Legislature amended section 2229 to unambiguously declare that "[p]rotection of the public shall be the highest priority for the Division of Medical Quality"⁹ Physician rehabilitation is still recognized as a goal for DMQ in exercising its disciplinary authority; however, "[w]here rehabilitation and protection are inconsistent, protection shall be paramount."¹⁰

⁸ *Arnett v. Dal Cielo* (1996) 14 Cal. 4th 4, 10.

⁹ Bus. & Prof. Code § 2229(a), added by 1990 Cal. Stat. 1597.

¹⁰ Bus. & Prof. Code § 2229(c). This declaration of legislative intent was later replicated for MBC generally in AB 269 (Correa) (Chapter 107, Statutes of 2002), which added section 2001.1 to the Business and Professions Code. Section 2001.1 declares that "[p]rotection of the public shall be the highest priority of the Medical Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent

Enforcement is expensive. Consistent with prior years dating back to the early 1990s, MBC spent 75% of its \$41 million budget — over \$30 million — on enforcement in fiscal year 2004–05.

C. MBC's Diversion Program

The Medical Board's Diversion Program was created in 1980 legislation that enacted Business and Professions Code section 2340 *et seq.* In the enabling legislation, the Legislature stated its intent “that the Medical Board of California seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety.”¹¹ Consistent with MBC's chief priority of public protection, this language thus requires the Board to “identify and rehabilitate” impaired physicians and return them to the practice of medicine, but only if this can be done “in a manner which will not endanger the public health and safety.”

Although the enabling language makes reference to physicians with mental or physical illness, the Diversion Program has historically been structured to monitor substance-abusing physicians. Participants in the Diversion Program include physicians who voluntarily seek help (“self-referrals”), physicians who are referred by the Board's enforcement program during investigation of a complaint (“Board-referred”), and physicians who are ordered to participate by DMQ as a term of probation in a formal disciplinary order (“Board-ordered”). Regardless of method of entry, each participant is required to enter into a contract with the Program. In the contract, the participant agrees to abstain from the use of drugs and alcohol, submit to random bodily fluids testing, attend support group meetings with similarly impaired physicians, undergo psychotherapy and/or substance abuse treatment, retain a “worksite monitor,” and cease practicing medicine if so instructed by the Program due to relapse or other noncompliance with the terms of the contract.

The Division of Medical Quality is statutorily responsible for overseeing the Diversion Program,¹² which is administered by a staff of twelve MBC employees. Although several of the Program's components (including bodily fluids collection, laboratory testing, and facilitation of support group meetings) have been contracted to the private sector, the “case management” function of the program and overall Program administration have been housed within the Medical Board since the Program's inception in 1981. The overhead costs of the Program — almost \$1.2 million in

with other interests sought to be promoted, the protection of the public shall be paramount.”

¹¹ Bus. & Prof. Code § 2340.

¹² *Id.* § 2346.

2004–05 — are subsidized entirely through licensing fees paid by all California physicians. As of June 30, 2005, 232 physicians were admitted to and participating in the Diversion Program.